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A Multi-Level Approach to Tackling the SARS-CoV-2 Pandemic and Its Aftermath

Abstract

Objectives: The SARS-CoV-2 pandemic brought about a new, difficult situation. The world, the international organisations-cum-regional integration arrangements, as well as, above all, individual states all had to cope with the difficult global situation. As for the European Union, neither the Union nor the Member States were prepared for such a challenge, which is why the responses were *ad hoc* and uncoordinated. The aim of this study is to identify the actors involved, the measures they employed, and the extent to which their reactions converged. Another objective is to answer the question about whether their actions fit into the concept of multi-level coordination-cum-multi-level governance.

Research Design & Methods: The methods used in this article are descriptive and interpretative as well as comparative. The descriptive method is applied in all these instances where actions taken by individual actors are discussed, while the interpretative method is employed when the reasons for taking particular measures are explained. In turn, the comparative approach is applied whenever measures taken by individual actors are juxtaposed. This analytical study also provides an overview of official documents along with the relevant literature.

Findings: In the face of the SARS-CoV-2 pandemic – when imminent and consistent response is essential, and when there are many decision-making centres – it is measures taken at different levels and by various actors (but jointly coordinated) that can only bring the desirable results. The measures taken in the struggle against the pandemic and its consequences also prove that the EU's competences, albeit limited, do matter.

Implications / Recommendations: When the primary competence in the field of public health lies with the Member States and the EU can only support and complement state actions, then a permanent, institutionalised cooperation, one based on a multilateral agreement, is worth considering.

Contribution / Value Added: In the case of international and regional organisations, and those with a global reach, a major drawback is the lack of appropriate competences and instruments. In the EU, the lack of a systemic security mechanism anchored in the EU's law makes it act with delay. On the one hand, this study points to the shortcomings in legal solutions, but on the other, it demonstrates the importance of joint and coordinated actions. It also shows that competences of non-state actors do matter, too.

Keywords: SARS-CoV-2, European Union, multi-level governance, coordination, crisis

Article classification: research article

JEL classification: K20, K32

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Basic facts and general observations

The SARS-CoV-2 pandemic (also known as COVID-19 or coronavirus) is not a new phenomenon. In the 21st century alone, the world has already been hit by plagues such as: SARS (2002–2004), swine flu (2009), and Ebola (2014–2016). As for the current pandemic, there had been warnings of an impending threat, followed by reports on a new type of virus (A world, 2019; Protecting, 2016). Thus, states did have timely information in possession, including warnings from the World Health Organization (WHO); however, they did not take any measures, or at least nothing is known about them. The reasons for such a passive attitude can be traced to a narrow understanding of national security, which is due to a thinking line shaped by the neoliberal paradigm[1] (or, rather, the neoliberal economic model)[2] and the contemporary capitalism reducing almost everything to economic categories. Such thinking, driven by economic calculations, was also conducive to the wishful thinking of those decision-makers who wanted to avoid too high costs. The desire to avoid social and political costs was one of the reasons for delaying the adoption of measures to reduce morbidity and death, such as restricting or even suspending activities in certain sectors. There was a fear that these measures would entail enormous costs, i.e. so high that impossible to make up for. There could also be ideological reasons, especially when it comes to liberal democracies, which are particularly sensitive to the limitation of citizens' rights and liberties.

The epidemic caused by SARS-CoV-2, which broke out in Wuhan (China), quickly spread to other countries and continents, becoming a pandemic with far-reaching consequences. To combat it, measures were implemented, including isolating disease outbreaks and maintaining social distancing, closing borders and suspending international flights, as well as restrictions on transport of certain goods. The measures were taken, for there was no other alternative, *inter alia* due to the limited capacity of healthcare systems[3]. The pandemic – and then the accompanying crisis caused, among other things, by the limitation or even suspension of economic activities – made it very clear that in an increasingly interdependent world not only benefits but also costs and difficulties are shared.

The theoretical framework and research design

The theoretical foundation for this study is the concept of multi-level governance, which can be applied for instance when many decision-making centres come into play, i.e. national (states along with sub-state units), supranational (the EU), and global (e.g. the World Trade Organization (WTO)). In turn, the aim of this study is to identify the actors involved, the measures they applied, and the degree of convergence in their responses. Another objective is to answer the question about

[1] This paradigm had broken down long before the COVID-19 pandemic started, forcing states to take control and intervene in order to prevent economies from collapsing. Even more importantly, the COVID-19 pandemic revealed the failure of the free-market mechanisms. For more information on the neoliberal paradigm, see Welsh, 2020. For more on public health, see Antentas, 2020, p. 432. Antentas also speaks of the return of a special kind of Keynesianism (a transitory-instrumental-emergency Keynesianism and an inverted-upwards Keynesianism) (2020, p. 434).

[2] The neoliberal economic model has dictated the world economy since the time of economic growth after the Second World War. It stands, *inter alia*, for the abolition of welfare programmes, minimum wages, price controls, import and export tariffs, high corporate taxes, and government participation in the economy. For more information on the neoliberal economic model, see: Dine & Koutsias, 2013, pp. 5–22.

[3] In recent decades, many countries implemented policies to curb public spending. Despite the UN stressing the need to strengthen health resilience, investments in public health systems declined, thereby increasing vulnerability and aggravating negative effects of the current pandemic. See also Zanin et al. (2020), or Renda and Castro (2020), where one can read: "In a world dominated by the quest for economic efficiency, with financial markets ready to award a premium to governments reducing public spending and thereby taxes, there is little place for resilience-oriented policy" (pp. 278–279). See also: Sendai, 2015.

whether they fit into the concept of multi-level governance.

As is widely known, competence is a prerequisite for any activity. In the case of the EU, the Member States are primarily responsible for public health issues. Given the side effects of the pandemic in terms of the functioning of the common market, the measures taken by the EU would be the best solution. However, in a situation where, on the one hand, the EU's competences are limited, and, on the other, the nature of the pandemic is global, the optimal mode of conduct seems to be about the coordination of activities (in terms of purpose, time, degree, and type)[4] at various levels: national (states along with sub-state units), the EU (institutions), and universal international organisations (the WHO operating within the system of the United Nations). Thus, it is only concerted actions that can bring the desirable results; it is about measures taken at different levels and coordinated jointly. This is the research thesis of this study.

The used methods are descriptive and interpretative as well as comparative. The main field of exemplification is the EU, its Member States, and the WHO. As the pandemic is still developing, there are many materials providing an insight into the situation, namely information from media reports, press releases, and studies in the form of papers published in scientific journals, such as the *European Journal of Risk Regulation*, special issue *Taming COVID-19 By Regulation*. Additionally, this study refers to official documents and reports from the Member States and EU institutions as well as international organisations, such as the WHO.

The discussion will proceed as follows: first, the concept of multi-level governance will be discussed, followed by measures taken by the WHO, the EU, and the Member States. These considerations will culminate in a discussion of the results and some concluding remarks.

[4] See also: Dobbs, 2020, p. 240.

Multi-level governance as a concept and theoretical approach

Especially in the 1990s, a number of works promoting the concept of multi-level (multi-tiered) governance emerged on the publishing market. Their authors emphasised the importance of the concept of multi-level governance in research on the EU. Generally speaking, multi-level governance refers to the idea of complex arrangements for making authoritative decisions in dense networks of public and private as well as individual and collective actors. It also refers to the change that is taking place in the states in the light of the processes of European integration (Piattoni, 2010, p. 1).

The origins of the concept can be traced back to the neofunctional theory of the European integration. It was first used by Gary Marks in the context of the EU's structural policy (Bache, Bartle, & Flinders, 2016, p. 486). The concept itself has been developed for use in the EU's decision-making. It points to vertical and horizontal relationships, whereby the former relates to interactions between governments acting at different territorial levels, whereas the latter concerns interactions between governmental and nongovernmental actors. In other words, the first one corresponds to multi-level, whereas the latter is linked to governance (rather than government) (Bache, Bartle, & Flinders, 2016, p. 486). While levels relate to territorially defined jurisdictions where decisions are taken by parliaments, executives, and public administrations in processes involving both public and private actors, governance relates to structures and processes of policy-making across the boundaries of jurisdictions and institutions (Benz, 2019, p. 388). Hence, multi-level governance concerns not only structural features, but also political processes and coordination mechanisms between levels (Benz, 2007, p. 298).

In the literature of the subject, a distinction is made between type-I and type-II governance. The former one relates to the governing setting where authority is dispersed and narrowed down to

a limited number of non-overlapping jurisdictions on a limited number of territorial levels, each responsible for specific functions. On the other hand, the latter one relates to the governing setting where the authority is task-specific, and jurisdictions operate at numerous levels and might be overlapping (Bache, Bartle, & Flinders, 2016, pp. 487–488). As can be seen, the first type refers to levels, whereas the second type involves horizontal linkages. What is more, the type-I jurisdictions can be international, national, regional, meso or local, with multiple functions and responsibilities, whereas the type-II jurisdictions are specialised and abundant, and governance is fragmented into functional units (Hooghe & Marks, 2003, p. 236). According to Liesbet Hooghe and Gary Marks, each type of governance has its distinctive positive traits and brings some benefits. The type-I governance is oriented towards intrinsic communities and their demands for self-rule, whereas the type-II jurisdictions are well suited to achieving pareto optimality when redistribution is not salient. Moreover, both deliver flexibility: the former by creating general-purpose jurisdictions with non-intersecting membership, whereas the latter – with special-purpose jurisdictions that tailor the membership, the rules of operation, and the functions to specific policy issues (Hooghe & Marks, 2010, p. 28).

International organisations' response to the pandemic

The International Health Regulations (IHR), which were adopted by the World Health Assembly on May 23, 2005, strengthened the coordination of the preparedness to respond to public health emergencies between states (Revision, 2005). Since all the Member States of the EU are simultaneously members of the WHO, the EU's legal acts should take account of the WHO's integrated approach, which covers all categories of threats, regardless of their origin.

On January 30, 2020, the WHO's emergency committee issued a statement that the coronavirus, which had broken out in China and spread to 18 countries, met the criteria for a public health emergency of international concern (Statement, 2020). On March 11, 2020, the agency officially declared the COVID-19 pandemic (WHO, 2020). In turn, on March 24, 2020, the then Director-General of the WTO Roberto Azevêdo asked the states-members of the organisation to submit information on trade and trade-related measures as well as the policies they had introduced in response to the coronavirus outbreak. He also set up a task force of experts to monitor the impact of COVID-19 on trade flows and the global economy (DG Azevêdo, 2020). On April 3, 2020, the WTO published a report on trade in medical supplies, which comprised an overview of the tariffs imposed on medical goods, which were thought proper in the context of tackling COVID-19 (World, 2020). Earlier, i.e. on the 26th of March, at an extraordinary summit, the G20 countries unanimously stated in a joint statement that they remained committed to international cooperation and working together in order to facilitate the international trade and coordinate responses to threats (G20, 2020). Then, on April 6, 2020, the World Customs Organization (WCO) and the WTO issued a joint statement in which they pledged to establish a coordinated approach in support of initiatives that facilitate cross-border trade in goods, especially those to combat COVID-19 (WCO–WTO, 2020). And then, a joint statement by the Directors-General of the FAO, the WHO, and the WTO said that since millions of people depended on the international trade for food, security, and livelihoods, states should ensure that trade-related measures do not disrupt the food supply chain (Food, 2020). On the other hand, the UN Security Council unanimously passed a resolution stating that the unprecedented extent of the COVID-19 pandemic was likely to endanger the international peace and security, and called upon all parties to armed conflicts to engage in a durable humanitarian pause in order to enable the delivery of humanitarian assistance (Resolution, 2020b, pp. 1–2). Also, the UN General Assembly passed a resolution on international

cooperation to ensure global access to medicines, vaccines, and medical equipment to make tackling COVID-19 easier (Resolution, 2020a, pp. 1–2).

As can be seen, many organisations responded to the challenges caused by the pandemic, and many initiatives were launched. One of them is the Access to COVID-19 Tools (ACT) Accelerator – global cooperation to speed up the development, production, and equitable access to tests, treatments, and vaccines; the WHO has been an important party here. Attention should also be paid to the landmark resolution to fight against the pandemic, adopted on May 19, 2020, by the World Health Assembly, which calls for the intensification of efforts to control the pandemic as well as for fair access to – and distribution of – all essential health technologies and products (COVID, 2020). Indeed, when it comes to health issues, a great role and responsibility falls upon the WHO to make the tests and tools to combat COVID-19 available to everyone, but above all to those in need, i.e. people from low- and middle-income countries.

The European Union's response to the pandemic – the question of competences

The pandemic, which affected all the EU's Member States, albeit to varying extents, translated into yet another crisis in the history of the European integration. However, the current COVID-19 crisis differs from the previous financial crisis in that it is wider in scope, as it affected states, nations, societies, and individuals, and put a strain on health systems, revealing their numerous flaws. In the light of a rapidly deteriorating situation, there was a need for an urgent and coordinated action, which is why it was natural for the states to turn to the EU.

The competences that the EU has at its disposal remain limited, although they permeate each and every sphere of the Member States. Unlike the individual Member States, the EU acts according to the principle of conferral, hence it does not have a competence-competence[5]. The EU enjoys only such competences that the Member States had agreed on, and these essentially relate to the common market. As a result, the EU has neither institutions that would make effective crises management possible, nor the appropriate means to combat COVID-19 (Micklitz, 2020, p. 249). However, given cross-border effects, which no country could cope with, this task fell to the EU despite the fact that it lacks appropriate competences and a strong democratically-legitimised political power. Since decentralised and uncoordinated crisis management entailed *spillovers* that were detrimental to the public health, the economy, and the fundamental values, there was an urgent need for coordination, mutual learning, and solidarity (Pacces, 2020, p. 284).

Decentralised solutions driven by local priorities can create tensions in cross-border relations, and it is not just about decentralised containment policies, but also risk management and, thus, a possible disruption of supply chains. The free movement of goods, and especially of medical supplies and equipment, became such an issue. Given the divergent interests, side effects, and potential conflicts, a coordinated policy was needed in order to mitigate the said effects and increase the effectiveness of responses to COVID-19.

It should be said that institutions of the EU and of any Member State could have already engaged in joint procurement procedures to advance the purchase of medical countermeasures for the purposes of serious cross-border threats to health (Decision, 2013a, art. 5), for it is extremely important to eliminate harmful competition with regard to vaccines and medical equipment. Even

[5] In the German language, one speaks of *Kompetenz-Kompetenz*, while in the French language it is *compétence de la compétence*. 'Competence-competence' is the central feature of a state and it comes down to the ability to 'give' oneself new competences; in other words, it is the right to assign and change one's own competences. According to the German Constitutional Court, *Kompetenz-Kompetenz* is the competence to decide on its own competence (BVerfG, para 233).

though the EU launched appropriate procedures, national governments' participation on voluntary basis reduced the EU's ability to react quickly in the common interest. Furthermore, under the 2004 regulation, the European Centre for Disease Prevention and Control (ECDC) was established (Regulation, 2004) – an independent agency that provides scientific advice, assistance, and expertise. Its mission is to identify, asses, and inform about the current and emerging threats to human health from communicable diseases (Regulation, 2004, art. 3). However, despite the ECDC's warnings against the high potential impact of the outbreaks of 2019-nCoV (the novel 2019 coronavirus) and its likely global spread (Communicable, 2020), the states did not act together. Also, under the 1998 decision, the Early Warning and Response System (EWRS) for the prevention and control of diseases was set up (Decision, 1998). Article 10 of the decision states the need to foster cooperation with third countries and international organisations competent in public health issues. It is the ECDC that supports and assists the Commission by operating the EWRS (Regulation, 2004, art. 8).

References to public health could already be found in the Treaty establishing the European Economic Community (1957) (Treaties, 1987), whose Article 36 speaks of prohibitions or restrictions on import, export or transit, justified, *inter alia*, on the grounds of health protection, while Article 56 speaks of legislative and administrative provisions that provide for special treatment of foreigners and are justified, *inter alia*, with reasons of public health. Further references to public health could be found in the Single European Act (Single, 1987): Article 18 (art. 100a TEEC) refers to the harmonisation of legal provisions, Article 21 (art. 118 TEEC) is on social policy, and Article 25 (art. 130r TEEC) concerns the environment. In turn, the Treaty of Maastricht (Treaty, 1992) introduced title X (public health) to the Treaty establishing the European Community (TEC) – Article 129 para. 1 subpara. 1 speaks of the Community contributing to ensuring a high level of human health protection, while subpara. 2 reads that the Community's action is directed towards the prevention of diseases, in particular major health scourges. *Ipso facto*, public health became a Community policy.

As already mentioned, the Member States were the first to take measures, even if this resulted in violations of fundamental freedoms. Then, what could explain this passive attitude of the EU? What competence does the EU have at its disposal regarding public health? Under the Treaty of Lisbon (Treaty, 2016), the EU enjoys three types of competences: one that is exclusive (art. 3 TFEU), one that is shared with the Member States (art. 4 TFEU), and the competence to support, coordinate, or supplement actions of the Member States (art. 6 TFEU). Article 6 letter a speaks of the protection and improvement of human health; Article 168 para. 1 says that a high level of human health protection should be ensured in the definition and implementation of all EU's policies and activities; subpara. 2 says that the EU's action, which should complement national policies, also includes monitoring, early warning, and combating serious cross-border threats to health. In para. 5, in turn, one can read that the European Parliament (EP) and the Council may adopt incentive measures to protect and improve human health, excluding, however, any harmonisation of the laws and regulations of the Member States. There are also other provisions, such as title XXIII on civil protection, which mentions the EU's action to support and complement the Member States' action in risk prevention and in preparing their civil-protection personnel (art. 196 para. 1 letter a TFEU). Here, the EP and the Council also can adopt measures necessary to help achieve the set objectives, excluding, again, any harmonisation of the laws and regulations of the Member States (art. 196 para. 2 TFEU).

In the absence of a vaccine, states resorted to traditional measures, i.e. social distancing and shutting down certain sectors of their economies – responses which were justified, but which with time generated high economic and social costs. Since the measures taken by individual states affected

the single market due to cross-border effects, especially when the restrictions were lifted, the EU stepped in. Although states' responses followed a similar path, an uncoordinated approach to easing (lifting) restrictions could have had a negative impact (Alemanno, 2020, p. 314; Roloff, 2020, p. 30). This might be the answer to the question about why the EU stepped in when the Member States moved to the next phase and started lifting restrictions.

In March 2020, the European Council called for an exit strategy coordinated with the Member States. The joint European Roadmap towards lifting the COVID-19 containment measures was presented by the President of the European Commission and the President of the European Council. The Roadmap set out recommendations to the Member States to preserve public health while gradually lifting containment measures; it also provided a frame for ensuring EU-level and cross-border coordination while recognising the specificities of each Member State (Joint, 2020, p. 2). Further, it set criteria for assessing when to start rolling back confinement measures (epidemiological, health system capacity, and monitoring capacity) and what the principles are which the EU and the Member States should be guided by when lifting restrictive measures (action based on science, coordination, respect, and solidarity) (Joint, 2020, pp. 4–5). According to Alberto Alemanno, the Roadmap struck a fine balance between, on the one hand, the need for the EU-wide coordination, and on the other, the Member States' country-specific needs; it was an attempt at internalising cross-border effects and operationalising competences in a situation of emergency (Alemanno, 2020, p. 315).

The crisis accompanying the pandemic accelerated the adoption of other measures, such as the implementing of regulation establishing an export authorisation, required for the export of personal protective equipment (PPE) outside the EU, whether or not it originated in the EU (Commission, 2020a). It was France and Germany that had already imposed restrictions on exports of protective medical equipment (Carreño, 2020, pp. 403–404), thus causing distortions on the internal market. Furthermore, the Commission decided to grant a relief from import duties as well as VAT exemption on import of goods, which were needed to combat the effects of the COVID-19 outbreak (Commission, 2020b). Other measures included joint procurement procedure (Communication, 2020a, art. 5), common criteria for legitimate border restrictions (Guidelines, 2020; Communication, 2020b; Communication, 2020c), green lines to protect health and to ensure the availability of goods and essential services (Communication, 2020d), as well as measures focusing on exit strategies, mainly with regard to social distancing. The Commission also came out with a proposal for a regulation regarding specific measures to mobilise investments in the Member States' health care systems and in other sectors in response to the COVID-19 outbreak, by mobilising cash reserves in the European Structural and Investments Funds (Proposal, 2020; Regulation, 2020). It increased the amount of *de minimis* aid granted by states to enterprises to 800,000 EUR (Communication, 2020e, point 22 letter a), allowed for the use of domestic funds to ensure access to liquidity and finance, facilitated COVID-19 research and development, supported the construction and upgrading of testing facilities of COVID-19 relevant products, and enabled the setting up of additional capacities for the manufacturing of products needed to respond to the outbreak (Communication, 2020f).

In earlier crises (SARS and Ebola), an important coordinating role was played by an informal group composed of representatives of the Member States, namely the Health Security Committee (HSC) (Decision, 2013a, art. 17), originally set up in 2001. The 2013 decision obliged the Member States to consult each other within the HSC and to coordinate, in liaison with the Commission, national responses to a serious cross-border threat to health, as well as risk and crisis communication (Decision, 2013a, art. 11 para. 1). This risk assessment and risk management coordination should, in turn, contribute to a high level of public health protection

(Pacces, 2020, p. 291). As for the current crises, an expert group was set up – composed of experts in, among other things, public health – to advise the Commission on measures to be taken at the EU level or to be recommended to the Member States for consistent, science-based, and coordinated risk management and risk communication (European, 2020a, art. 4), with the president of the Commission as a chair and the Commissioner for health as a vice-chair (European, 2020a, art. 6). Thus, there is a coordination at the EU level by means of a dialogue between technical (ECDC and expert panel) and political (HSC) bodies (Morvillo, 2020, p. 374).

Currently, the EU and the Member States are working together towards developing a common approach to safe COVID-19 vaccines, coordinating testing strategies, and facilitating the supply of protective and medical equipment.

The Member States' response to the pandemic

The main protagonists in the fight against the COVID-19 pandemic were states, i.e. governments and political leaders. Due to its scale and consequences, the pandemic became a strong political impulse. According to Hans-Wolfgang Micklitz (2020), one can even speak of the revival of the political through states that were saving lives of citizens and protecting population in border regions by establishing safety nets for economies, employees, and companies (pp. 249–250). It should be added that an effective crisis management at a state level depends on the proper functioning of key sectors of the economy, such as production, food supply, banking, healthcare, transport, IT services, and energy supplies – goods and services provided by international and domestic entities. As for the common market, it did not disintegrate, at least as regards cross-border trade, whereas personal freedoms, including free movement of persons and economic activity in sectors not considered essential, were suspended (Micklitz, 2020, pp. 249–250).

When an epidemic crosses national borders and becomes a pandemic, it should be treated as a matter of a common concern. However, contrary to what one might think, it was still treated as a national problem. In response to the pandemic, the Member States adopted their own, often differing countermeasures. However, despite an initial hesitation, states converged in their approaches and followed a similar path. The exceptions were Sweden and the United Kingdom (UK). Sweden decided not to implement lockdown, arguing that the best remedy to overcome the pandemic is to wait for the main wave of cases to pass and the population to become immune[6]. This does not, however, mean that no measures were taken, but much was left to the discretion of the people. A large part of the population decided to voluntarily distance themselves, work from home, and refrain from travelling. On the other hand, the government banned gatherings of over 50 people, visits to nursing homes for the elderly, and closed high schools and universities. In short, the country was dealing with a voluntary application of preventive measures and a responsible behaviour of individuals. In turn, in the UK, the so-called 'herd immunity strategy' was adopted. However, due to questionable results, lockdown was ordered eventually – the decision heavily criticised as being at least two weeks overdue. The UK should be treated as a special case in the context of Brexit and the withdrawal from the EU on January 31, 2020. No longer a Member State[7], its economic entities operate on the common market until an agreement on future relationships with the EU is signed or the transition period ends.

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[6] In the statement by Sweden's ambassador to the USA, one can read: "We believe the combination of voluntary and mandated measures is not only more sustainable for Sweden than a lockdown strategy but will strengthen the resilience of Swedish society to fight this virus in the long run" (Olofsdotter, 2020).

[7] In the EC's communication, one can find: "United Kingdom, being treated as a member of the EU until the end of the transition period" (Communication, 2020d, p. 3).

The EU States' responses to the COVID-19 pandemic pose the question about what caused the initial attitude. Was it the scale of the threat, limited resources, a fear of social resistance (civil disobedience), which manifested especially in the Netherlands (Janssen et al., 2020)? Or was it more about the style of governing resulting from the political culture, or perhaps merely a negative attitude of society to any kind of restrictions? As states' responses began to converge, social distancing became their main focus. Virtually all Member States required some social distancing, along with specific individual measures such as: bans on mass gatherings; closures of workplaces, schools, and universities; and restrictions on the movement of people, both domestically and internationally. Most states mandated the wearing of face masks, with the ECDC recommending the use of face masks as complementary to – and not a substitute for – the core preventive measures to reduce community transmission (Using, 2020). What is more, some states declared a state of emergency, while others (e.g. Poland) an epidemic. As mentioned, although initially there had been significant differences in countries' responses, they did converge with time. First of all, states began to imitate those countries which were hit first and most. This happened spontaneously, without the involvement of the EU and its mechanisms for cross-border crisis coordination (Alemanno, 2020, p. 311). While this emulation led to a relatively quick convergence of national responses, it translated into different combinations of regulatory interventions, which could explain some raised concerns under the EU's law due to cross-border spillovers (Alemanno, 2020, p. 311).

Currently, we are experiencing another wave of the pandemic and, therefore, each Member State is imposing some kind of restrictive measures.

Handling the COVID-19 crisis – assessment and recommendations

Faced with the pandemic, states were the first to take measures, which, however, affected the functioning of the common market, as restrictions can infringe fundamental market freedoms, even if they are justified by higher values, such as public health. It is even believed that this situation will advance their transformation into steering states[8], as it is states that will have to assure that healthcare sectors never again suffer from shortages and that key industries necessary to fight the pandemic are located in the EU (Micklitz, 2020, p. 253). What is even more important, human health became a priority; it can even be said that it regained its due place[9]; however, it will take time to see how long the trend will continue and whether it will be lasting.

How important timely reactions are could be seen in the case of Italy. The number of deaths would have been significantly lower had the quarantine been ordered at least two weeks in advance and had the population complied with the recommendations[10]. The lack of an immediate response from decision-makers led to the very large number of cases in a very short time. Was it because decision-makers treated the economy as a priority, while the danger of pandemic as exaggerated? Or did they think that since the epicentre was in the distant China, there was no reason to panic? Regardless of what states were driven by, the fact is that they delayed actions and responded only when health systems were at their limits.

Regarding the EU, more coordinated action sought by the Commission would have been desirable – attempts were made too late and were hindered by fragmented governance and the lack of a EU-wide framework for risk and crisis

[8] See also Micklitz (2020, p. 253), where the author writes: "The COVID-19 threat is supposed to strengthen the transformation of the nation state into a steering state – «l'État Providence» in the format of the precautionary state."

[9] See also Micklitz (2020, p. 250), where he states: "The COVID-19 threat dictates the order of assistance – health first, then money; society first, the economy second."

[10] See also Rudan (2020, p. 6), where he says: "At least 100 times fewer people would be dying in Italy these days had they declared a quarantine for Lombardy two weeks earlier than they did."

management (Renda & Castro, 2020, p. 274). Although the EU has legal instruments and a dedicated agency, when it comes to public health it cannot harmonise the laws of the Member States – an important issue when dealing with cross-border health threats that require coordinated action (Renda & Castro, 2020, p. 277). The ECDC issued recommendations on criteria for registering patients with COVID-19, maintaining social distancing, and tracing contacts; the Commission published recommendations on testing strategies; and, recently, the Council has adopted a recommendation on restrictions to free movement (Council, 2020). However, these measures are not binding and it is up to the Member States who to test, whether to trace contacts, and what social distancing measures to apply (Renda & Castro, 2020, pp. 277–278). While some measures – such as quarantine, school closure, or even the suspension of economic activities – can be applied at national and regional levels, there is still a need for a coordinated approach to stop the spread of communicable diseases (Renda & Castro, 2020, pp. 278–279). Hence, a greater degree of centralisation would be desirable. Though there is some, albeit limited, centralisation, the WHO's and ECDC's activities essentially focus on collecting and sharing research results and providing guidance. Even if the EU adopted a decision that allows for the joint procurement of medical equipment, and if the Commission worked out a coordinated exit strategy, the core competences still remain with the Member States.

With limited competence in public health, however, the EU can act in other areas, e.g. it can finance joint research, including research into vaccines, treatments, and medical equipment (art. 180 TFEU), as well as it has a solidarity clause at its disposal (art. 222 TFEU), which may be invoked by the Member States (Council, 2014) to pool resources under the Civil Protection Mechanism (Decision, 2013b). In March 2019, this mechanism was reinforced by the rescEU capabilities (Decision, 2019), which allowed the Commission to establish a strategic rescEU medical stockpile and a distribution mechanism (Purnhagen et al., 2020, p. 299). The EU can also adopt measures that improve health as long as they remove obstacles to trade or significant distortions of competition, amend packaging laws to stop COVID-19 from spreading on hard surfaces, protect environment, and promote mutual recognition of fast-track qualifications (Purnhagen et al., 2020, pp. 300–301). What is more, the COVID-19 outbreak made it possible to apply Article 107 para. 3 letter b TFEU, which enabled the Commission to approve national supporting measures to remedy serious economic disturbances.

The EU has also a residual competence at its disposal in order to achieve one of the objectives in case the treaty does not provide for a specific competence. Social progress is such an objective (art. 3 para. 3 TEU). Measures adopted under Article 352 TFUE might not entail the harmonisation of the Member States' laws and regulations where the treaty rules out such a harmonisation (art. 352 para. 3 TFEU). States can also make use of the Integrated Political Crisis Response (IPCR) mechanism (Council, 2018), which allows for a timely coordination and response at the EU level in case of crisis, regardless of whether it originates inside or outside the EU. The said mechanism was activated on February 28, 2020, by Croatia. Equally important is the EU's budget and additional funds dedicated to the post-crisis reconstruction of Europe – such as the EU's Next Generation instrument – to support the recovery in the aftermath of the COVID-19 crisis, which was established under a recently adopted regulation.

The COVID-19 situation also advanced the debate on enhanced cooperation, a Union of variable geometry, and solidarity (European, 2020b). On the other hand, however, voices in favour of establishing the European Health Union were raised. Such a union, along with a biomedical research agency, would strengthen the EU's health security framework and enhance the preparedness and ability to respond to crisis situations.

Concluding remarks

The COVID-19 crisis left its stigma on social, economic, and political life of citizens, societies, national communities, and states. It led to an unprecedented restriction of freedom due to limitations on movement and the need for social distancing. In sectors where mainly small and medium-sized enterprises are present, the economy, production, and services were limited or even suspended. Politically, since it was necessary to make quick decisions, the executive branch was strengthened. As for society, social distancing affected social ties and mental health as well as people's beliefs, priorities, plans, and expectations.

The actors involved, measures applied, and the degree to which their responses converged were all analysed at three levels: global, regional, and national. Vertical relations, which were discussed, fit into the concept of multi-level governance of type I. It needs to be said that the linkages are the most pronounced between the EU and the Member States, and the least between the WHO and other actors. The reasons for this can be sought in competences, instruments, and means of influence that these organisations have at their disposal. Thus, the concept of multi-level governance, originally applied in the EU context, turns out to be a useful research tool, for it can also be applied to constellations other than the EU itself. It works particularly well where there is a need to manage public policies – one of which is public health – in a decentralised environment.

The COVID-19 crisis also highlighted the importance of an imminent and consistent response. Due to the global reach of health problems, the world is dealing with many decision-making levels and centres, i.e. actors with different competences, priorities, and interests. However, only a concerted response could bring the desired results, i.e. measures taken at different levels (national, regional, global), by various actors (states and international organisations), and jointly coordinated. When it comes to the EU, it needs to be said that its competences to monitor health threats and to assess risks are insufficient, especially when an immediate response is needed, but they are not without significance.

The current pandemic is not only a painful experience, but also an opportunity to rethink policies and draw conclusions for further development. It can already be said that COVID-19, which tests the limits of the EU's competences in the field of public health, will become a catalyst for progress in crisis situations. It also proves that the EU's competences, albeit limited, do matter. And, as in any crisis situation, it became possible to take measures that would otherwise be impossible.

When the primary competence in the field of public health lies with the Member States and the EU can only support and complement state actions, then a permanent, institutionalised cooperation, one based on a multilateral agreement, is worth considering. This also applies to the wider international context.

References

Alemanno, A. (2020). The European Response to COVID19: From Regulatory Emulation to Regulatory Coordination. *EJRR*, *11*(2), 307–316.

Antentas, J. M. (2020). Coronavirus: Notes on crisis, borders and the future of neoliberalism. *Geographica Helvetica*, *75*(4), 431–436.

Bache, I., Bartle, I., & Flinders, M. (2016). Multi-level governance. In Ch. Ansell & J. Torfing (Eds.), *Multi-level governance: Handbook on theories of governance* (pp. 486–498). Edward Elgar Publishing.

Benz, A. (2007). Multilevel Governance. In A. Benz, S. Lütz, U. Schimank, & G. Simonis (Eds.), *Handbuch Governance. Theoretische Grundlagen und empirische Anwendungsfelder* (pp. 297–310). VS Verlag für Sozialwissenschaften.

Benz, A. (2019). Conclusion: Governing Under the Condition of Complexity. In N. Behnke, J. Broschek, & J. Sonnicksen (Eds.), *Configurations, Dynamics and Mechanisms of Multilevel Governance* (pp. 387–409). Springer International Publishing.

Carreño, I., Dolle, T., Brandenburger, M., & Medina, L. (2020). The implications of the COVID-19 pandemic on trade. *EJRR*, *11*(2), 402–410.

Dine, J. & Koutsias, M. (2013). *The Nature of Corporate Governance: The Significance of National Cultural Identity*. Edward Elgar Publishing.

Dobbs, M. (2020). National Governance of Public Health Responses in a Pandemic? *EJRR*, *11*(2), 240–248.

Hooghe, L. & Marks, G. (2003). Unraveling the Central State, but How? Types of Multi-Level Governance. *The American Political Science Review*, *97*(2), 233–243.

Hooghe, L., & Marks, G. (2010). Types of multi-level governance. In H. Enderlein, S. Wälti, & M. Zürn (Eds.), *Handbook on multi-level governance* (pp. 17–31). Edward Elgar Publishing.

Micklitz, H.-W. (2020). The COVID-19 Threat: An Opportunity to Rethink the European Economic Constitution and European Private Law. *EJRR*, *11*(2), 249–255.

Morvillo, M. (2020). I Just Can't Get Enough (of Experts): The Numbers of COVID-19 and the Need for a European Approach to Testing. *EJRR*, *11*(2), 366–374.

Pacces, A. M. & Weimer, M. (2020). From diversity to coordination: A European approach to COVID-19. *EJRR*, *11*(2), 283–296.

Piattoni, S. (2010). *The theory of multi-level governance: Conceptual, empirical, and normative challenges*. Oxford University Press,

Purnhagen, K. P., de Ruijter, A., Flear, M. L., Hervey, T. K., & Herwig, A. (2020). More Competences than You Knew? The Web of Health Competence for European Union Action in Response to the COVID-19 Outbreak, *EJRR*, *11*(2), 297–306.

Renda, A. & Castro, R. J. (2020). Towards Stronger EU Governance of Health Threats after the COVID-19 Pandemic. *EJRR*, *11*(2), 273–282.

Roloff, R. (2020). COVID-19 and No One's World: What Impact for the European Union? *Connections QJ*, *19*(2), 25–36.

Rudan, I. (2019). A cascade of causes that led to the COVID-19 tragedy in Italy and in other European Union countries. *J Glob Health*, *10*(1), 1–10.

Welsh, J. (2020). Struggling beyond the paradigm of Neoliberalism. *Thesis Eleven*, *158*(1), 58–80.

Zanin, G. M., Gentile, E., Parisi, A., & Spasiano, D. (2020). A Preliminary Evaluation of the Public Risk Perception Related to the COVID-19 Health Emergency in Italy. *International Journal of Environmental Research and Public Health*, *17*(9), 3024–3044.

BVerfG, 2 BvE 2/08 the judgment of the Second Senate of 30 June, 2009.

(a) Communication from the Commission Guidance from the European Commission on using the public procurement framework in the emergency situation related to the COVID-19 crisis (OJ C 108I, 1.4.2020, pp. 1–5).

(b) Communication from the Commission to the European Parliament, the European Council and the Council covid-19: Temporary Restriction on Non-Essential Travel to the EU (COM/2020/115 final).

(c) Communication from the Commission COVID-19 Guidance on the implementation of the temporary restriction on non-essential travel to the EU, on the facilitation of transit arrangements for the repatriation of EU citizens, and on the effects on visa policy (OJ C 102I, 30.3.2020, pp. 3–11).

(d) Communication from the Commission on the implementation of the Green Lanes under the Guidelines for border management measures to protect health and ensure the availability of goods and essential services (OJ C 96I, 24.3.2020, pp. 1–7).

(e) Communication from the Commission Temporary Framework for State aid measures to support the economy in the current COVID-19 outbreak (OJ C 91I, 20.3.2020, pp. 1–9).

(f) Communication from the Commission Amendment to the Temporary Framework for State aid measures to support the economy in the current COVID-19 outbreak (OJ C 112I, 4.4.2020, pp. 1–9).

(a) Commission implementing regulation (EU) 2020/402 of 14 March 2020 making the exportation of certain products subject to the production of an export authorisation (OJ L 77I, 15.3.2020, pp. 1–7) no longer in force.

(b) Commission Decision (EU) 2020/491 of 3 April 2020 on relief from import duties and VAT exemption on importation granted for goods needed to combat the effects of the COVID-19 outbreak during 2020 (OJ L 103I, 3.4.2020, pp. 1–3).

Council Decision of 24 June 2014 on the arrangements for the implementation by the Union of the solidarity clause (OJ L 192, 1.7.2014, pp. 53–58).

Council Implementing Decision (EU) 2018/1993 of 11 December 2018 on the EU Integrated Political Crisis Response Arrangements (OJ L 320, 17.12.2018, pp. 28–34).

Council Recommendation (EU) 2020/1475 of 13 October 2020 on a coordinated approach to the restriction

of free movement in response to the COVID-19 pandemic (OJ L 337, 14.10.2020, pp. 3–9).
COVID-19 response, Seventy-third world health assembly, WHA73.1, 19 May, 2020 (pp. 1–7).
Decision No 2119/98/EC of the European Parliament and of the Council of 24 September 1998 setting up a network for the epidemiological surveillance and control of communicable diseases in the Community (OJ L 268, 3.10.1998, pp. 1–7).
(a) Decision No 1082/2013/EU of the European Parliament and of the Council of 22 October 2013 on serious cross-border threats to health and repealing Decision No 2119/98/EC (OJ L 293, 5.11.2013, pp. 1–15).
(b) Decision No 1313/2013/EU of the European Parliament and of the Council of 17 December 2013 on a Union Civil Protection Mechanism (OJ L 347, 20.12.2013, pp. 924–947).
Decision (EU) 2019/420 of the European Parliament and of the Council of 13 March 2019 amending Decision No 1313/2013/EU on a Union Civil Protection Mechanism (OJ L 77I, 20.3.2019, pp. 1–15).
(a) European Commission Decision of 16.3.2020 setting up the Commission's advisory panel on COVID-19, Brussels, 16.3.2020 C(2020) 1799 final.
Guidelines for border management measures to protect health and ensure the availability of goods and essential services (OJ C 86I,16.3.2020, pp. 1–4).
Joint European Roadmap towards lifting COVID-19 containment measures 2020/C 126/01 (OJ C 126, 17.4.2020, pp. 1–11).
Proposal for a Regulation of the European Parliament and of the Council amending Regulation (EU) No 1303/2013, Regulation (EU) No 1301/2013 and Regulation (EU) No 508/2014 as regards specific measures to mobilise investments in the health care systems of the Member States and in other sectors of their economies in response to the COVID-19 outbreak (COM/2020/113 final).
Protecting humanity from future health crises. Report of the High-level Panel on the Global Response to Health Crises, 9 February, 2016 (A/70/723).
Regulation (EC) No 851/2004 of the European Parliament and of the Council of 21 April, 2004, establishing a European Centre for disease prevention and control (OJ L 142, 30.4.2004, pp. 1–11).
Regulation (EU) 2020/460 of the European Parliament and of the Council of 30 March, 2020, amending Regulations (EU) No 1301/2013, (EU) No 1303/2013 and (EU) No 508/2014 as regards specific measures to mobilise investments in the healthcare systems of Member States and in other sectors of their economies in response to the COVID-19 outbreak (Coronavirus Response Investment Initiative) (OJ L 99, 31.3.2020, pp. 5–8).
(a) Resolution 74/274 adopted by the General Assembly on 20 April, 2020 (A/RES/74/274).
(b) Resolution 2532 (2020) adopted by the Security Council on 1 July, 2020 (S/RES/2532 (2020)).
Single European Act (OJ L 169, 29.6.1987).
Treaties establishing the European Communities (1987). Luxembourg: Office for Official Publications of the European Communities.
Treaty on European Union (OJ C 191, 29.7.1992).
Treaty on European Union and Treaty on the Functioning of the European Union (consolidated version OJ C 202, 7.6.2016).
A world at risk: Annual report on global preparedness for health emergencies, Global Preparedness Monitoring Board (GPMB), World Health Organization (WHO), September 2019; https://apps.who.int/gpmb/assets/annual_report/GPMB_annualreport_2019.pdf.
Communicable Disease Threats Report, Week 4, ECDC, 19–25 January 2020; https://www.ecdc.europa.eu/en/publications-data/communicable-disease-threats-report-19-25-january-2020-week-4.
DG Azevêdo requests WTO members to share information on trade measures related to COVID-19, 25 March, 2020; https://www.wto.org/english/news_e/news20_e/dgra_24mar20_e.htm.
(b) European solidarity in the face of COVID-19, 22 April, 2020; https://cy.ambafrance.org/European-solidarity-in-the-face-of-COVID-19.
Food and Agriculture Organization of the United Nations, *Mitigating impacts of COVID-19 on food trade and markets*, 31 March 2020; http://www.fao.org/news/story/en/item/1268719/icode.
G20 Leaders' Statement, Extraordinary G20 Leaders' Summit Statement on COVID-19, 26 March, 2020; https://g20.org/en/media/Documents/G20_Extraordinary%20G20%20Leaders%E2%80%99%20Summit_Statement_EN%20(3).pdf.
Janssen, D., Kucharczyk, M., & Pazura. N. (2020). Koronawirus: Protesty w Holandii przeciwko ograniczeniom społecznym, 6 May, 2020; https://www.euractiv.pl/section/bezpieczenstwo-i-obrona/news/koronawirus-protest-haga-holandia-ograniczenia-restrykcje-lockdown-epidemia.
Olofsdotter, K. (2020). Op-Ed: Sweden refused to impose a coronavirus lockdown. The country's ambassador

explains why, Los Angeles Times, 2 May, 2020; https://www.latimes.com/opinion/story/2020-05-02/sweden-coronavirus-voluntary-strategy.

Revision of the International Health Regulations (2005); https://apps.who.int/iris/bitstream/handle/10665/20353/WHA58_3-en.pdf?sequence=1&isAllowed=y.

Sendai Framework for Disaster Risk Reduction 2015–2030, UNDRR (2015); https://www.undrr.org/publication/sendai-framework-disaster-risk-reduction-2015-2030.

Statement on the second meeting of the International Health Regulations (2005). *Emergency Committee regarding the outbreak of novel coronavirus* (2019-nCoV), Geneva, 30 January, 2020; https://www.who.int/news-room/detail/30-01-2020-statement-on-the-second-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-the-outbreak-of-novel-coronavirus-(2019-ncov).

Using face masks in the community: Reducing COVID-19 transmission from potentially asymptomatic or pre-symptomatic people through the use of face masks, ECDC, Stockholm, 8 April, 2020; https://www.ecdc.europa.eu/sites/default/files/documents/COVID-19-use-face-masks-community.pdf.

WCO–WTO Joint Statement on COVID-19 related trade measures, 6 April, 2020; http://www.wcoomd.org/en/media/newsroom/2020/april/wco-wto-joint-statement-on-covid-19-related-trade-measures.aspx.

WHO Director-General's opening remarks at the media briefing on COVID-19, 11 March, 2020; https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020.

World Trade Organization, Trade in medical goods in the context of tackling COVID-19, 3 April, 2020; https://www.wto.org/english/news_e/news20_e/rese_03apr20_e.pdf.